PRINTED: 04/03/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS2677AGC 11/13/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10019 PRINCESS CUT ST **PRINCESS 2 GROUP HOME** LAS VEGAS, NV 89123 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 Y 000 **Initial Comments** The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of the annual state licensure survey conducted at your facility on 11/13/08. The survey was conducted using Nevada Administrative Code (NAC) 449, Residential Facility for Groups Regulations, adopted by the Nevada State Board of Health on July 14, 2006. The facility is licensed for six Residential Facility for Group beds for elderly and disabled persons. Category I residents, and/or persons with mental illnesses. The census at the time of the survey was six. Six resident files were reviewed and three employee files were reviewed. One discharged resident file was reviewed. The following regulatory deficiencies were identified: Y 072 Y 072 449.196(3) Qualications of Caregiver-Med SS=D re-training NAC 449.196

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

must:

3. If a caregiver assists a resident of a residential facility in the administration of any medication, including, without limitation, an over-the-counter medication or dietary supplement, the caregiver

(a) Receive, in addition to the training required pursuant to NRS 449.037, at least 3 hours of training in the management of medication. The caregiver must receive the training at least every

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Bureau of Health Care Quality & Compliance

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS2677AGC			B. WING		11/13/2008	
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		0.2000
PRINCESS 2 GROUP HOME		10019 PRINCESS CUT ST LAS VEGAS, NV 89123				
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This Regulation is not met as evidenced by: Based on record review on 11/13/08, the facility failed to document medication management training for 1 of 3 employees (#1). Findings include: Employee #1's file lacked documentation of medication management training. Severity: 2 Scope: 1 449.209(4)(b) Health and Sanitation-Hazards NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (b) Hazards, including obstacles that impede the free movement of residents within and outside the facility. This Regulation is not met as evidenced by: Based on observation and interview on 11/13/08, the facility failed to keep the premises free from hazards.		Y 175				
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Findings include:

Severity: 2 Scope: 3

The files of Employees #1, #2, and #3 lacked documentation of mental illness training.

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Employee #2 indicated she administered the Trazodone to Resident #1 for insomnia.

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